AUTHORIZATION TO LINK EXTERNAL PRIMARY CARE PROVIDER

_____ grants permission to have the following
Healthy Connections Primary Care Provider

provider(s) linked to Healthy Connections referral number _____.

External Medicaid Provider Name	Medicaid Billing Number	Gender of Clients Accepted	Age Range of Clients Accepted	Effective Date of Linkage
		☐ Both ☐ Male ☐ Female	☐ A 0-18 ☐ B 15-44 ☐ C 15-120 ☐ D 55-120 ☐ E All Ages	
		☐ Both ☐ Male ☐ Female	☐ A 0-18 ☐ B 15-44 ☐ C 15-120 ☐ D 55-120 ☐ E All Ages	
		☐ Both ☐ Male ☐ Female	☐ A 0-18 ☐ B 15-44 ☐ C 15-120 ☐ D 55-120 ☐ E All Ages	

I/We understand that having a provider linked to my/our referral number will allow said provider(s) to use my/our referral number:

- To provide services to my/our Healthy Connections patients without a referral
- To authorize other services for Healthy Connections patients using my/our referral number.

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- When other providers are linked to my referral number, the linking cannot be effective for only certain periods of time (i.e. for just after-hours coverage).
- This authorization must be revoked in writing.

Date: _____

Signature: _____
Healthy Connections Primary Care Provider and/authorized individual

Please fax completed form to Healthy Connections Staff at _____

For information, please contact Healthy Connections Staff at _____

Revised 02/09/2005